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THE EFFECTIVENESS OF
GROUP WORK WITH
NURSING HOME RESIDENTS

A Thesis

Presented to

The Faculty of the Department of Social Work

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

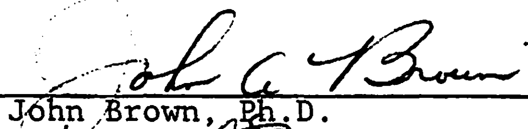
Master of Social Work

By

Cheryl Lee Hoag

December, 1984

APPROVED FOR THE DEPARTMENT OF SOCIAL WORK



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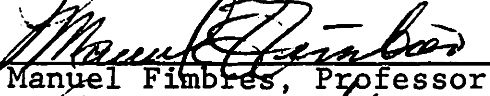

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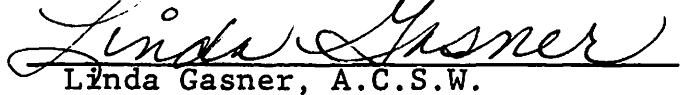

Linda Gasner, A.C.S.W.

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CHAPTER 1

Introduction

Background and Rationale

Anyone who interacts with senior citizens cannot help but appreciate and recognize the intense struggles of their daily life. This age group, particularly, suffers from emotional neglect within the nursing home environment. While a "good" nursing home provides wholesome meals, clean rooms, proper medication dispensing, and appropriate nursing care, little attention may be paid to psychosocial programs for the institutionalized elderly.

This problem is even more severe in light of the fact that today over one million (approximately 5 percent) aged persons are living out their lives in nursing homes in the United States (Wetzel, 1980). The reason for this is probably due to the fact that life expectancy was forty-seven years at the turn of the century; whereas improved medical and health services have boosted today's average life expectancy to 71.2 years (Shivers and Fait, 1980). In addition, according to Shivers and Fait (1980:187), "Between 80 and 90 percent of those who enter nursing homes die within a relatively short time, one-third within a year of entry, one-third within three years, and the final third three or more years later."

Large groups of senior citizens are now entering nursing homes where social isolation is not an uncommon phenomena. It is not uncommon to find nursing home residents sitting next to each other without speaking a single word to one another. This phenomena has been coined communicative-cognitive dysfunction (Feier and Leight, 1981). Residents, for instance, may sit and watch a television movie and not discuss the program. Due to lack of interest in their surroundings, conversation is minimal or inappropriate. It seems their life revolves around going to the lunchroom, returning to their bed, and sleeping. Most spare time is spent gazing or looking into space.

It is easy to understand how a nursing home resident would feel rejected and abandoned upon entering a nursing home. The resident has not only had to part with loved ones, friends, and family members, but he has also lost familiar routine activities and fond memories. Daily routines, such as walking to the store, eating lunch in a favorite restaurant or feeding the family pet, come to a halt. An independent senior citizen who finds himself in an unfamiliar environment, where rigid procedures and orders characterize the day, often becomes depressed. In fact, Wetzel (1980) characterizes environmental control as an antecedent variable of depression, regardless of dependence or independence orientation.

To further increase social isolation, staff members distance themselves from residents either because of

professional status or the high mortality rates found in nursing homes. In addition, it is very difficult for the resident to establish any kind of relationship with the nursing staff because of high turnover rate. Alicia S. Cook (1981:422) emphasizes this point when she writes, "Nurses' aides, who comprise the largest percentage of staff employed in nursing homes and have four times as much contact with residents as do the professional staff, also have the highest turnover rate."

"A lack of interest in the world and a lack of interest in self-development, indicators of dependent behavior leading to vulnerability to depression, are typical of the depressed elderly," states Wetzel (1980:236). Through lack of input or cultivation, minds may become quite barren through neglect (Ebersole, 1978a). Nursing home institutions seem only to accelerate these symptoms of depression, creating feelings of hopelessness. However, the loss of rights, privileges, and independence upon entry into a long-term care facility need not be perpetuated. Alternatives for intervention are available.

Most recently, as a group leader in the Nursing Home Care Unit at Palo Alto Veterans Administration Medical Center, it became apparent that implementation of an elderly group of nursing home residents, who were inactive, lonely, and depressed, would be a positive force within the nursing home environment. The investigator believed that not only would

the group give nursing home residents the opportunity to improve their psychosocial functioning, but would also provide insight, knowledge, and better understanding of their environment. As Emanuel Tropp (1968:267) states so accurately, "What better way to do it than to give them the opportunity to make it happen, not after they leave the agency, but while they are enjoying its hospitality, with the worker as part of the common enterprise, in groups in which they share with others some common concern."

Purpose, one of the most important considerations in establishing an elderly resident group, enabled the investigator to focus on specific goals and the ways in which these goals and objectives could be carried out. There were many purposes for establishing a group for elderly residents, including a need to improve self-concept, increase social interaction, maintain awareness of the environment, and improve communication abilities among the residents. More specific goals included having a purpose to dress up, receive compliments, ask questions of others and respond appropriately to questions.

Another important consideration or purpose in establishing the group was to provide a favorable environment which encouraged self-expression and decision-making. There was a need for nursing home residents to discuss problems they were having with ward personnel or fellow residents. As one resident stated to a staff member, "I need to know who to

go to when there is a disruptive resident sitting at the breakfast table." Tropp (1968:270), emphasizing the need for meaningful group experience, wrote, "One discovers the simple truth that people with similar interests, similar concerns or similar problems can help each other in ways that are significantly different from the ways in which a worker can help them in a one-to-one relationship."

The overall function of the group was to address the psychosocial needs of elderly in long-term care. The group was to provide an environment of opportunity for members to gain self-esteem, meet needs for social interaction, assume roles within the nursing home, and maintain ties with the family and the "past." In reality, it was important that the group function as a mutual aid system, where members could come together for sharing and solving common problems. Sharing data, debating ideas, empathizing, working on sensitive issues and obtaining valuable information seem to be a significant part of the mutual aid process (Shulman, 1979). The group, in essence, was to become a "tool" where elderly persons could be validated as unique persons who have contributed to the richness of their world.

Problem Statement

This study was set up to identify the effects of a small group experience upon the psychosocial functioning of nursing home residents. How do senior citizens perceive and act

upon their environment (structurally) when they belong to a supportive group that actively seeks the mutual aid process? This question was a guide for the investigator in data collection and analysis of the phenomenon of elderly small group process. Until the present, it has been found that there have been few studies which have evaluated the effectiveness of group work with the institutionalized elderly (Burnside, 1970).

Research Statement

To investigate the effect that an elderly activity group might have on the psychosocial well-being of the senior citizens within the Veterans Administration Nursing Home Care Unit, the investigator was guided by the following research statement:

> The nursing home activity group will lead to improvement of the nursing home residents' psychosocial functioning within the usual nursing home setting.

Research Goals and Objectives

The following research goals provided guidance for the investigator in determining whether the activity group would have a positive effect on the psychosocial functioning of long-term nursing home residents.

I. To increase self-esteem of the attending group members.

   A. Preserving dignity by simple acts of kindness, such as ensuring properly fitted hearing aids.

II. To create an atmosphere of acceptance, understanding and caring concern.

A. Ties with the community - Supporting outings to movies, plays, or restaurants.

B. Ties with the past - Activities can validate an individual's background and lifestyle.

III. To increase feelings of autonomy and mastery of one's environment within the nursing home setting.

A. Replacing past roles with new roles, such as church member, group member, treasurer, or philosopher.

IV. To provide a learning opportunity where issues relevant to the aging are discussed.

A. Topics, such as death, loss, bereavement, and reminiscing provide valuable information to the aged resident.

V. To provide solutions to problems nursing home residents may have on a day to day basis.

A. Answering questions to common problems can decrease much anxiety the resident deals with on a daily basis.

VI. To stimulate involvement so that residents have a real sense of belonging, as opposed to social isolation.

A. Providing activities, such as special dinner outings, can stimulate involvement.

To accomplish these goals, certain criteria were observed and evaluated. Resident psychosocial functioning was evaluated by considering the following questions:

I. Psychosocial Functioning

A. Is the resident experiencing less depression and exhaustion?

B. Is there increased interaction with group and non-group members?

C. Is knowledge gained by material presented during group meetings?

D. Is the resident feeling more positive toward self and life in general?

Major Variables and Operational Definitions

In order to fulfill this study it was imperative that the following concepts be operationally defined: (1) Who is a skilled nursing home resident? (2) What is an "activity" group? and (3) How will psychosocial functioning be measured?

1. The skilled nursing home is designed for veterans who are neither acutely ill nor in need of hospital care, but who require skilled nursing care and related medical services. Skilled nursing care includes individuals with chronic or permanent physical or mental impairments because of the periodic or continuous medical services that will be required for them. Even though the definition does not include the "acutely ill," it does encompass those individuals who are: (1) chronically ill, (2) exhibit permanent or residual disability, (3) require long-term rehabilitative efforts, and (4) long periods of nursing supervision, observation and care.

Skilled nursing care is a very global term which can be clarified even further by defining the four characteristics previously mentioned. First, chronic is defined in Dorlan's Illustrated Medical Dictionary (1983:7) as "persisting over a long period of time." Therefore, chronic illness may be

defined as an illness that persists over a long period of time; as opposed to acute illness, which has a short and relatively severe course. Second, the term disability, according to Goldenson (1978:xvii), may be defined as "any chronic, physical or mental incapacity resulting from injury, disease or congenital defect." Third, rehabilitation "comprises any process, procedure, or program designed to enable the affected individual to function at a more adequate and personally satisfying level (Goldenson, 1978:xvii)."

In order to determine the fourth characteristic, long periods of nursing supervision, the index of the activities of daily living (ADL) has been developed to measure health and illness status (Katz and others, 1970). For example, at the Veterans Administration Nursing Home Care Unit, there are six activities which are coded, with score ranges from one, independent in all six functions, to seven, dependent in all six functions. Those residents who are rated seven are dependent in feeding, continence, transferring, going to the toilet, dressing and bathing. The activities of daily living, in effect, reveals the "amount" of personal assistance needed by a resident of a nursing home within the Veterans Administration Medical Center.

2. According to Shulman (1979:268), "Activity group is a term usually applied to groups involved in a range of activities other than just conversation." It may be seen as a group which depends on activities as the channel for

"therapeutic" communication. Some of the "tools" used to carry out the activity group include crafts, games, music, recreational activity interests, and past reminiscing. The physical setting for an activity group often involves the use of a large, brightly furnished room, which allows for the preparation and serving of refreshments. The totality of the above mentioned group situation and interaction further provides definition to the term activity group.

3. In determining nursing home residents' psychosocial functioning, the variable depression was measured through the use of the following scales: (1) Brief Symptom Inventory Scale (BSI), (2) Mood Assessment Scale (MA), and (3) Morale Quality Scale (MQ).

I. Operational Definitions of Major Scales

A. Brief Symptom Inventory Scale: A questionnaire consisting of fifty-three questions which measures for various symptoms.

1. The symptoms include somatization, depression, phobic anxiety, obsessive-compulsive, anxiety, paranoid ideation, inter-sensitivity, hostility, and psychoticism.

a. The intensity of distress ranges from zero, not at all distressed, to four, extremely distressed.

B. Mood Assessment Scale: A questionnaire consisting of thirty questions that use the following scores to determine depression:

1. 0-9 Normal Mood, 10-19 Mild Depression, and 20-30 Severe Depression.

C. Morale Quality Scale: A questionnaire consisting of nine questions that ask the respondent how satisfied he is with his life.

   1. The nominal scale uses the following rating of yes, no and don't know to determine life satisfaction.

CHAPTER 2

Literature Review

Elderly are not mindless, purposeless individuals. They are people who have the right to continued growth and learning in every part of their daily life (Feier and Leight, 1981). Today they are the fastest growing group in the population. In 1977, 11 percent (23 million) of Americans were regarded as the retirement age at sixty-five years; however, there will be an estimated 31 million elderly citizens (sixty-five or older) by the turn of the century (O'Morrow, 1980). Of this population of elderly, about one million are found in nursing homes and institutions (O'Morrow, 1981; Shivers and Fait, 1980; Berger, 1979). According to Butler and Lewis (1982:296), "The average age of nursing home residents is eighty years; 70 percent are women and 90 percent are white." Most elderly who enter nursing homes die there and it appears that the average stay is one year.

There are excellent nursing homes in the community. However, there still exists a remainder of homes that provide unhealthy living conditions. They run the gamut from sterile, antiseptically clean dormitories to dark, dank seemingly endless hallways. Residents are often seen pacing the hallways or blankly staring at walls in total silence. In addition, staff members are often untrained, poorly supervised,

and insensitive toward elderly patients. Poorly trained staff, inadequate nutritional food, lack of entertainment and personal abuse of residents by staff members are just a few of the problems that lead to an environment of deep frustration and grief associated with institutionalization (Butler and Lewis, 1982).

The elderly, upon entering a skilled nursing facility, lose (and have lost) many human needs which are essential for human growth. Sociologist, Abraham Maslow, defined the following five needs which he felt were necessary for growth: (1) physiological needs, (2) safety and security needs, (3) love and affiliation, (4) self-esteem, and (5) self-actualization (Cook, 1981). However, the love and affiliation, self-esteem and self-actualization human needs seem to be the most significant needs of the elderly person. It is without a doubt, that most aged nursing home residents extend a great amount of energy and focus on meeting these unmet needs.

A nursing home resident who enters a nursing home has already suffered losses that range from loss of family members and friends to loss of a familiar way of life. However, according to O'Morrow (1980:141), "Man commonly attempts to overcome his aloneness by establishing lasting interpersonal relationships with others." In other words, a resident will not have a sense of "belonging" if he is unsuccessful in seeking affectional relationships with other nursing home

residents. Kubie and Landau (1953) in their book, Group Work with the Aged, wrote that the elderly person's need to recite a long list of physical ailments may have been an expression for human contact.

A lack of self-esteem and identity is, also, often felt by the elderly. Self-esteem, through previous mentioned losses, plunges to an all time low for many aged persons who enter a nursing home. In the nursing home setting the resident is viewed as dependent, slow, unproductive and useless. These characteristics define the resident as a "less valued" human being who is not contributing to society (Ness, 1973).

In addition, the elderly face role changes when they enter the institution. Berger (1979) outlined three major role changes that elderly persons must face: (1) change from an active caretaker to dependent patient, (2) change from health role to sick role, and (3) change from family member to institutional resident. It is clear that the elderly people in this society make up the sick role of the elderly. Once institutionalized, elderly people become dependent and remain in the sick role as disabled individuals. In a society that values accomplishment, effort, intelligence, and wholesomeness, the aged person becomes a less valued member. In essence, it reflects a society which does not value the older citizen (Kubie and Landau, 1953).

Self-actualization can only be accomplished by elderly persons when they gain the respect that tells them they are appreciated, competent, and productive. According to Cook (1981), this can only be realized through opportunity to develop one's potential and self-awareness. By removing the barriers at the lower level hierarchy of human needs, full potential can develop.

As previously stated, nursing homes, for the most part, are not pleasant places to reside. Past efforts made to maintain elderly communicative skills and to alleviate boredom and loneliness have had a poor record of success. Nursing home activities, such as television, cards, bingo, ice-cream socials and arts and crafts, have fallen short in increasing resident interest and communication. These are merely isolated non-unifying events that attempt to increase resident involvement in the nursing home environment. Feier and Leight (1981) have even suggested that intellectual decline has been caused and promoted by purposeless activities and programs within the nursing home.

Activities, however, do not need to be purposeless. According to Carroll (1978:6), "Activities must do more than produce an occasional bright spot of entertainment ...; activities must help people learn new information, skills, or behaviors or improve their feelings of self-worth and independence." In other words, activities can be therapeutic as long as they provide stimulation, social interaction and

allow for individuality. It is important that activities be altered to make the resident stand out as someone unique and different. Adaption is the key to increasing resident participation and enjoyment. Although there are many different kinds of activities to meet patient needs, what seems important is that these activities be purposeful and goal oriented.

What seems to be more important than participation in activities is the knowledge of belonging to a specific group. Shivers and Fait (1980:51) write most appropriately about the impact of group participation:

> For whatever reasons, individuals tend to join or affiliate themselves with others in order to participate in satisfying activities; to effect some outcome; to attempt to wield influence in their own right; to compensate for the roles that have been lost through retirement, displacement, or death of the spouse, or to relieve any feeling of loneliness or isolation brought about by such conditions.

Shulman (1979) refers to the group as a separate entity, or in metaphorical terms as an "organism," that is more than just the totality of each member's contribution. By examining group pressures, expectations, and purpose, an individual's behavior can be explained. Groups have, also, been defined as a collection of organisms in which the existence of all members is necessary to the satisfaction of certain individual needs in each (Cartwright and Zander, 1960). That is to say, the group is basically an instrument toward the satisfaction of the needs of the individual. Cartwright and Zander (1960) further state that individuals

belong to the group because they achieve certain satisfactions made possible by its organization, which would not be so readily possible for them through any other device.

A group, however, does not exist within a vacuum. Rather, it is usually a small part of a larger social system, such as an institution or agency. Papell and Rothman (1966: 67) stress this point when they write, "Historically in group work theory and in its practice there has existed the eternal triangle of the individual, the small group, and the larger society." The group, in essence, bridges the gap between environment and individual change. In describing different group models, Papell and Rothman (1966) define the "reciprocal" group as that group which advances the helping process through a mutual-aid-system which is intended to serve both the individual and society.

Group therapy is such a valuable process that it should be widely used in institutions, including nursing homes. Groups can work toward increasing self-esteem and helping residents deal with illness or emotional problems. Nursing home residents, participating in groups, have the opportunity to use all of their personal resources, physiological, psychological, and social. Preoccupation with the "self" diminishes when there is a renewed interest in being part of the group. The feeling that one is aimlessly passing time decreases, allowing for a sense of purpose and active participation within the nursing home environment.

A review of selected literature on group work with the aged revealed few studies that measured the effectiveness of group work with the aged. It seems, however, that there have been a variety of groups led by imaginative group leaders who are social workers, nurses, psychiatrists, psychologists, occupational and recreational therapists. Group topics range from life review groups to psychoanalytic therapy groups.

One of the early forerunners in group work with the elderly was Kubie and Landau's (1953) published book which described their experiences in a recreation center for the aged. The book includes chapters on birthday parties, counseling, discussion groups, and self-government. One of the important concepts presented in this book is the belief that self-centeredness leads to rejection, and self-control and participation lead to the rewards of group approval and status. Through a process of resocialization, interactions that occur within the community will change into attitudes of cooperation with others.

Merrill (1967) described remotivation activity groups in his book, Activities for the Aged and Infirm. He saw remotivation as a technique used in hospital settings where conversation is used as a way to reach withdrawn patients to bring them back to reality. Patients are encouraged to take an interest in their surroundings by focusing on everyday life issues. Subjects for conversation include poetry,

history, geography, and national holidays. According to Merrill (1967:162), "The hope is that this technique will remotivate the patient - get him moving again - in the right direction."

The author felt discussion groups could center around old-fashioned ice-boxes, kitchens, fashions, and schools. For example, a group leader might ask questions such as: (1) What was the first school you remember? (2) Do you remember the school picnic? and (3) How many children were in your school? These questions awaken, in a withdrawn patient, a feeling of being included in a group meeting where dignity and self-respect are time honored. The author, also, felt that activities of this sort were invaluable in giving residents a new lease on life to make new friends, find new interests, and to learn to socialize and express themselves. In addition, group work of this sort tends to increase staff awareness of needs and problems of older residents (Burnside, 1970).

Dorothy Blake (1973) stated that interaction between group members and the group leader increased internal stimuli, thereby increasing ego strength. Therefore, she encouraged internal stimuli through the process of "life review" which includes returning to memory life experiences, particularly aspects of unresolved conflicts. Based more on psychosocial care of the aged, the life review goals include resocialization, sharing of life review process, and intervention. "Physical movement, touching, and being

touched, and describing appearances and actions," according to Blake (1973:158), "strengthen the elderly person's ability to deal more effectively with his environment."

Priscilla Pierre Ebersole (1978b) incorporated the life review process through the use of reminiscing groups. She believed there were many reasons for supporting reminiscing in a group. For example, it was her belief that reminiscing provided the following opportunities: (1) enhancing a cohort effect, (2) increasing socialization, (3) exchanging ideas, (4) increasing varied interactional possibilities, (5) promoting intergenerational understanding, (6) encouraging self-actualization and creativity, and (8) serving as a springboard for beginning other kinds of groups. She felt reminiscing groups could be a "launching tool" for moving into other types of groups that incorporate tasks, activities, current events, music, and art.

Ebersole (1978a:145) wrote, "All reminiscing, in my opinion, serves to increase one's sense of identity." She understands reminiscing as an opportunity to share the past and resolve the present within a setting of supportive interaction. Through interaction all kinds of emotional feelings are released. It can be painful as well as pleasurable. However, painful material shared in a group reduces individual pressure and provides for support when needed. Most importantly, Ebersole (1978a) describes reminiscing as a means to develop wisdom, integrity and resolution of finitude.

Lesser, Lazarus, Frankel, and Havasy (1981) initiated a study of the reminiscent group with psychotic and neurotic elderly persons. They found that reminiscence group therapy increased spontaneous verbalization, patient-to-patient interaction, and group cohesiveness. Overall, reminiscing was described as a means to "undercut anxiety and defensiveness, and even encourage some risk taking (Lesser and others, 1981: 295)."

Life-crisis groups have also been valuable in utilizing the creative use of reminiscence. Robert Butler and Myrna Lewis (1982), authors of the book, Aging and Mental Health, believe life crisis groups assist elderly in passing through phases of life difficulties. With a varied age group membership, topics can range from adolescent issues to adult problems with retirement, illness, divorce, and impending death. By bringing different age groups together there is an enriching exchange of experience. In addition, according to the authors, elderly persons provide ideal role models in resolving and finding solutions to problems of loss and grief. Historically, reminiscing over an entire life cycle also creates a sense of continuity and encouragement that suffering and disability can be overcome (Butler and Lewis, 1982).

A book about therapeutic activities programming (Carroll and others, 1978) encourages the use of activity groups. The authors' view activity groups as a way to stimulate involvement,

provide meaningful roles, create ties with the past, and provide learning opportunities on subjects relevant to aging. Social groups are seen as an opportunity for providing meaningful roles such as leader, philosopher, joker, organizer, friend, fellow group member or host and hostess. Activity group work validates an individual's background and lifestyle. Furthermore, these authors find death and bereavement to be a natural part of the human life cycle and should be shared in a group activity process with the aged.

Janice Wood Wetzel (1980:236), in further clarification of group activities, states, "Aides may be needed to help research the area of interest, providing resources in the form of reading material..., records and tapes, and visitors who have expertise in the given area." She stresses the need for group exercises to cover quiet and stationary activities such as review of events, reminiscing, and the arts. However, the group can also be active, concerning itself with cooking a meal, going on an outing, inviting a guest to share a special talent or gardening.

Task-mastery is, also, an important concept Wetzel (1980) presents to treat and prevent depression in aging women and men. She feels task mastery can counter a lack of self-esteem and well-being. The author believes, however, that the "task" must be important to the nursing home resident. Projects can also be broken down into increments to be worked on within the institution. In addition, she encourages family

involvement in the task for the purpose of providing an overall supportive environment. "Support of family needs will have a direct effect on the well-being of their elderly kin," states Wetzel (1980:237), "while reinforcing the existing natural helping network in the family."

O'Morrow (1980) supports many types of activities, such as entertainment, hobbies, music, outings and games. He finds entertainment as one type of activity that reaches the emotional and social aspects of the elderly resident. Hobbies are unique, according to the author, in that an elderly person enjoys sharing his many talents with a group. As an example, an avid stamp collector has much to offer a group, providing entertainment and interest, and in return receives recognition for what has always been an enjoyable activity. In addition, group activities that include excursions to museums, zoos, and art galleries allow aged residents to remain in contact with the greater society.

Reality orientation groups are described as another means of reaching the older generations (Hastings, 1981). Hastings (1981:207) writes, "The more an older person ignores the world around him or her, the less the world reacts to him or her." An imaginary or past world comes into focus for the resident rather than the present and real world. Disorientation occurs when a resident loses track of time, person, and place. To increase reality orientation, simple and varied activities can be initiated in a reality orientation group. Paper

cutting, clay modeling, and sensory stimulation activities are a few ways to begin reality groups. Advanced classes include current event discussions, group activities, and trips to the community.

Feier and Leight (1981), in exploring group work, believe that groups should have a leader, but one who does not always lead. The group leader basically serves as facilitator, rather than as teacher, encouraging the exploration of common problems, challenging obstacles which detract from group goals, establishing a mutual-aid system of common sharing of ideas, and lending a vision to the group and the outside systems (Papell and Rothman, 1966). In short, the group leader's role may vary along a dimension of no involvement to small involvement in terms of power and leadership. The potential for mutual-aid exists in the group where major decisions are made by the group as a whole, rather than by a professional who claims expertise in the problem area (Mayers, 1980). In conclusion, there are many topic discussions for a group, but what is important is that verbal and non-verbal communication be developed and accepted by the group leader.

As has been revealed, there are many different types of group work with elderly institutionalized residents in a variety of settings. Some therapists have found it to be more beneficial to become increasingly active with aged groups. Outside group activities, in some instances, were

viewed to be beneficial to group therapy. Others, however, take a more passive, psychoanalytic view, concentrating on increase of ego strength. What seems important, however, is that group leaders develop an ability to be flexible, accepting, and energetic group facilitators.

Questions did arise in the investigator's mind while reviewing the selected literature. Some of the pertinent questions were: (1) What major studies have been done to determine whether one type of group activity is more effective than another? (2) What type of group activity is more beneficial for the wheelchair, disoriented or neurotic resident? and (3) What kind of leadership is most appropriate for the varied population of aged found in institutions? These questions, through my research, remain unanswered for the most part and would provide valuable information for those professionals dedicated to enhancing the lives of the elderly.

CHAPTER 3

Description of Group Work Process

This chapter will highlight the investigator's experiences in leading a small group of nursing home residents at the Veterans Administration Nursing Home Care Unit in Menlo Park, California. It is hoped that some of these shared experiences, observations, and comments will assist other professionals who are interested and involved in group work with the elderly. The following information and material presented in this chapter highlights the data recorded from the initial fourteen meetings, during which the group met weekly.

Group Selection

In formulating the nursing home group the following criteria was used in selecting eligible residents: (1) mobility (including wheelchair residents), (2) verbal ability, (3) coherence, and (4) ability to sit for one hour weekly. A fairly clear idea as to which residents would benefit from group experience came from reviewing twenty psychosocial assessments, found in medical charts, and evaluating head nurse recommendations. The selection process turned out to be less difficult than expected because, after the interviews, ten members elected to become involved with the group.

This seemed to be an ideal number for a beginning group, especially since the investigator originally planned on a small group format with eight to ten members.

The weekly group meetings were held in a fairly large conference room each Friday at 10 a.m. Even though the room was bland in appearance, it was uncluttered and allowed for the presence of visual stimuli on all four walls. Even with wheelchairs, members were able to form a semi-circle each session, contributing to some rather exciting and stimulating conversations.

It was decided in the early formulation and planning of the group to have an open group format where new members would be allowed to join. Since it was expected that several members might drop the group, the investigator wanted to ensure that there would be at least eight members present for each session.

Group Description

It was difficult to lose three group members so early in the group formation process; however, one member had such a severe hearing loss that the group proved to be a source of frustration, rather than enjoyment. The second member to leave the group simply had difficulty sitting down for a full one hour session. For several sessions he paced in the back of the room making it difficult to concentrate on the group's business. The third member left due to his

disease, Huntington's Chorea. He felt a great deal of anxiety and frustration during group meetings when he could not control his body movements. It was most difficult to lose these group members. However, due to difficult physiological and psychological problems the group was not appropriate for meeting their needs.

It was encouraging, however, to have three new members added to the group over these same four sessions. The new members had been invited to the group through invitation by other members and suggestion by staff personnel. Throughout the following group sessions, many more members would join, bringing the total membership to a high of sixteen members. However, at no time did the membership drop below eight. In fact, eight "core" members regularly attended each session, providing consistency at all levels of group work. Of these eight core members, five were men and three were women. As shown in Table 1, all members were caucasian and two of the group members were married to one another (Mr. and Mrs. L).

Seating Arrangement

At each session, group members formed a semi-circle so that they faced one another. As the weeks passed it was evident that members became comfortable with their "places" in the conference room, often situating their wheelchairs or chairs in the same place for each meeting. The three women

Table 1

Patient Data on Group Members

Group Member	Age	Sex	Race	Medical Diagnosis	Length of Time in N.H.	Means of Mobility	Attendance
Mr. F	81	M	C	Thyroid	2 yr.	Walker	Absent 1
Mr. A	42	M	C	Stroke	4 mo.	Wheelchair	Absent 1
Mr. G	57	M	C	Multiple Sclerosis	1 yr.	Wheelchair	Perfect
Mr. O	62	M	C	Schiz.	1½ yr.	Ambulatory	Perfect
Mr. L	90	M	C	Good Health	1 yr.	Walker	Perfect
Mrs. L	89	F	C	Hip Fracture	1 yr.	Wheelchair	Absent 1
Mrs. M	86	F	C	Angina	2 yr.	Wheelchair	Absent 2
Mrs. H	88	F	C	Arthritis	2 yr.	Wheelchair	Absent 2

often sat together in the center of the circle with the male group members sitting in the periphery of the group.

Those who most consistently attended the group meetings were the outspoken members, anxious to participate in the group as a vehicle for change and providing new interests. The size of the group varied from eight to sixteen members, with an average of eleven members at any one time. Several members were unable to attend group on a regular basis because of scheduled medical appointments, family visits, or lengthy hospitalizations. One member, Mr. M., may have been a regular group member if it had not been for his poor health and hospitalizations. Overall, attendance was generally consistent, with only a few members who complained of discomfort during several meetings.

First Session

It is impossible to describe for the reader each and every group session that was recorded while the investigator was group leader. However, this chapter would be incomplete if the first session was not fully described. It was not only exciting, but important because it was the very first session. The investigator truly wanted it to be a success!

The primary goal for the first group session was to acquaint group members with one another. To assist in this venture, six feet of bright pink butcher paper was bought and taped to the conference room wall. On the paper were

written the following title headings: (1) name, (2) place of birth, (3) generation, (4) cultural identity, (5) place of residence, and (6) service years. There was, also, a small space left on the paper to record what each member was feeling during the first session. The butcher paper method proved to be such a success that it was later used in most of the following group sessions. In addition to the brightly colored paper, a conference table was set-up, decorated with home grown flowers, an assortment of knickknacks, coffee, and doughnuts.

When the first members arrived they were delighted with the way the room was decorated. It seemed as if they enjoyed the extra fuss made over them. Following introductions, the investigator explained the title headings, which were drawing great interest and frequent questioning. The nursing home residents, in attendance, appeared anxious to talk about their individual lives and upon inquiry presented many new facets of themselves that could not be documented in a medical record.

In discussing cultural identity, Mr. F. and Mrs. H. discovered they had a Danish background and proceeded to speak with each other in Danish. It was not only wonderful in the sense that their heritage was accepted in the group meeting; but their faces seemed to "glow" when reminiscing together. Mr. F. spoke a great deal about his immigration from Denmark, perhaps for the first time in many years. Not to be outdone,

Mr. G. spoke of his hometown in the Midwest, where he went to highschool with the movie actor, Charlie Weaver. This, of course, spurred others on to tell their story.

One incident occurred, however, which surprised the group members, not to mention the investigator! Mr. M., who later became ill and was unable to attend later group sessions, burst into tears as he told of the persecution of the Jews in Russia and his immigration to the United States with his family. During this painful moment all of the residents remained quiet, not clearly knowing where to look or what to do. As the investigator reached for Mr. M.'s arm and stroked it for a minute, he was able to share those painful moments with the group. He soon was able to hold back the tears and ask the group if he could present home slides of his homeland. Mr. G. offered a resounding "yes" and the other members affirmed his response.

Before the close of the first session several questions were presented which the members felt were imperative to answer before the group dispersed. The questions were: (1) What will the group be named? (2) How long will the group meet each week (already the group was running over the one hour limit)? and (3) What is the purpose of this group, when there already exists an elder veterans group in the next building? With some rather quick decision-making the "Friendly Social Group" was chosen as the name for the group. This was not an easy decision since three other names were offered

for selection. It was also agreed that one hour would be the time limit for the group because many members started to complain of back pain by the end of the first session.

Finally, Mr. G., in answering question three, described the group as a place where members could get to know each-other, rather than living in an atmosphere where residents go to a lunchroom and back to their rooms without speaking a word to each other. In addition, he explained the group as a much needed activity within the nursing home where activities and support could occur in the home where residents live.

There was a great sense of satisfaction in knowing that the group decided on their own the mission of the group and it's central purpose within this first important meeting. With this final summation, the meeting dispersed and Mr. F. remained to help clear the table and continue speaking Danish with Mrs. H. It was at this time the investigator realized the group's strength and knew that the group would develop the needed tools to produce change and personal growth.

Group Stages

Margaret Hartford (1969) has developed, in her analysis of group work, five group phases that can occur within a single session or over a longer period of time covering several group meetings. All groups develop and play out these phases over a course of time. The phases outlined by Hartford (1969)

include the following: (1) Pre-group Phase, (2) Group Formation Phase, (3) Integration, Disintegration, and Conflict Phase, (4) Group Functioning and Maintenance Phase, and (5) Termination Phase. These phases provide a view of the group process from its beginning to end, creating natural boundaries that enhance group evaluation.

For purpose of clarification, the investigator chose to use four of these phases, excluding the pre-group phase, to represent group development. The group formation phase, or initial phase, follows the first meeting of the group members. This phase is the "coming together" where shared group goals, norms, and identity emerge and develop. The second phase, or conflict phase, follows the initial phase with challenge and conflict, as a result of a strong move toward integration. This is a period of testing where conflict revolves around distribution of power and control. If the conflict goes unresolved, the group will disintegrate. If interpersonal conflicts can be resolved, within time, the group can coalesce and move into the group maintenance phase. The group then becomes involved in finding and carrying out means of goal accomplishment. A sense of "we" emerges and group identity is established (Hartford, 1969).

Finally, the group maintenance phase is followed by termination. The group dissolves because of loss of membership, leadership, incompletion of group goals, or failure to integrate. For whatever reason the group dissolves, the

termination process cannot be underestimated. Appropriately dealing with separation assists individuals in preparation for other terminations that may confront them throughout life (Hartford, 1969).

The nursing home group, like many groups, went through certain phases of development. These phases enabled the investigator to evaluate the group events with a clear frame of reference. Using the Hartford phases as a guide, the group stages used to represent the nursing home group's development included the group formation phase, conflict phase, group maintenance phase, and termination.

Group formation phase. During the first four sessions of the initial stage of group development there was clarification of group purpose and individual expectation. It was important to present to the group the recognition that often elderly members who have little interaction with others, including staff members, often become depressed and lonely. Residents seemed to identify with this problem and expressed their willingness to share their own personal feelings. Mr. G., for instance, often stated during group sessions that the need for members to get to know one another was very important. This comment was again reinforced in session three when, after viewing a fitness exercise film, several members commented that they needed to know themselves before entering a strict exercise program. The use of activity in this case assisted

in reaching underlying messages. What the residents were really saying was that they did not feel a part of the nursing home environment. This issue was an important one because the following group sessions would be devoted toward the residents' education and realization that the nursing home was their home and that they could make it a better place to live.

The initial phase was toasted with a large Thanksgiving Day dinner during the fourth session. It was almost as if the eight core members and four others were toasting themselves, along with the group. A solid bond of cohesiveness that had developed was toasted and the dinner was delightful, with full group participation, liveliness, humor, and song. Mr. F. sang in Danish and was the most vocal the group had ever seen him. Mr. O. actually invited a friend and stayed to enjoy the entire dinner. Mr. and Mrs. L. joined our group at this point in time and proved to complete the membership. Without a doubt, the dinner highlighted the initial stage with purpose and resolution to enter the second stage with new challenge and initiative.

Conflict phase. The second stage was characterized by conflict and power struggles between several individual group members. There was also some hostility directed toward nursing home staff, including the investigator. Sessions five through seven proved to be the most challenging, when there were times the group was surging ahead and other times when conflict

seemed to disunify the group.

Session five dealt exclusively with member disenchantment with nursing staff, recreational staff, physicians, and social workers. Even though confidentiality had been established, enabling members to speak out on concerns and problems within the nursing home, it was a surprise to hear such an onslaught of injustices. Yalom (1977:310) writes, "One of the consequences of suppression of therapist - directed anger . . . for most groups, is the emergence of displaced, off - target aggression." In part the group was trying to gain independence from the investigator's controlling leadership, which was interfering with their ability to reach their goals. However, some of their concerns about the nursing home were very real and by permitting confrontation, genuine work could begin. Therefore, it was important to allow the issues to present themselves for solution.

It seemed as if each group member held his own personal grudge. Mr. M., who was still with the group at this time, expressed a great deal of grief and frustration about being treated like a "baby" by nursing staff because of his disabilities. Mr. G. was dismayed that residents had so little voice in the organization of the nursing home. This, of course, created conflict with the women members who felt they were well treated by all medical staff and did not really want to play a significant part in the organization. At one point, a visiting member stated he was tired of the complaints

and abruptly left the meeting. The culmination of these complaints, however, resulted in an important group session with the Director of the nursing home. Together, patient needs and rights were addressed and later integrated into the fabric of the nursing home environment.

Sessions seven and eight closed the second stage with a much happier outlook. Since it was Christmas holidays, the group decided to thank staff members by presenting a potted plant and a box of candy. It seemed as if the group was integrating again and moving toward other important issues. By this time, anger towards staff had been expressed and there was a desire to move on to other interests. Mr. and Mrs. L. made a distinquished speech to their head nurse and Mr. F. became sentimental and tearful with his presentation to his nursing staff. It was a touched moment, with great warmth in the room, as the rest of the group members' watched the turn of events.

Group functioning and maintenance phase. Stage three of group development was characterized by intimacy and cohesiveness. Group members became involved with common tasks, enabling them to accomplish goals and objectives. This phase, also, involved the establishment of group norms and identity. The group was now ready to settle down to work.

Approximately two months from its beginning, members of the group decided to elect officers. Mr. G., in fact,

suggested that electing officers would make the group more formalized and official. The other group members agreed and an exciting, swift election was put into motion during the eighth session. According to Garland, Jones and Kolodney (1976:261), the third stage of development is characterized by "intensification of personal involvement . . ., a growing ability to plan and carry out group projects," and increasing trust and group cohesiveness.

Coplon and Strull (1983:263), in describing the third stage dynamics, write, "During this stage there are more sharing and spontaneous conversation because the group is much better equipped to guide itself, choose its own topics, and solve internal problems." For the "Friendly Group," sessions eight through twelve were indeed very active meetings where common issues were discussed and involvement was strong to remedy existing problems. As an example, five activities the group felt were important to initiate for the betterment of the nursing home community were: (1) development of an orientation book to present to new residents, (2) initiation of social activities to integrate and provide cohesion, (3) establishment of a treasury to collect dues for social functions, (4) arrangement for a functional day room, and (5) initiation to encourage guest speakers to present outside issues of concern to nursing home residents. Many activities were initiated during this phase, but the above list was not all inclusive.

The vitality of this group was demonstrated by the planning and organization of the nursing home orientation book (see Appendix A). Three elected members (by this time everything was done by election) met with a social worker, who was very much interested in the project, for several meetings during which they worked out the fine points of the book. When the full orientation book was complete and published the entire group displayed pride in having accomplished this important goal.

In addition to writing and participating in the orientation project, members were given the opportunity to present these small booklets to new incoming residents. These books allowed nursing home residents to become active again. It reaffirmed the fact that elderly people are vital citizens who can accomplish many tasks if allowed to do so. It was probably at this time that the "group-as-a-whole" experience evolved. The "group-as-a-whole" involves a quality of support within the group where individual members find that source of support during a difficult period or time in their lives (Shulman, 1979).

During this work phase accomplishments were numerous. It seemed there was a flurry of ideas and each one had special significance. Even though there were many issues of concern, only those items that the majority felt were important were addressed. The Valentines dinner, for instance, was of prime importance. There seemed to be a need within this group for

social activities, enabling them to entertain their families. They, also, wanted to hear from the world through guest speakers. In the beginning, the investigator could not understand the priority for this issue. However, as guest speakers arrived for various group sessions, it was amazing to hear the members' questions, advise-giving, and involvement.

Yalom (1977:312) describes this particular group phase when he writes, "The members, in a sense, unite against the rest of the world, with much intermember support, much pride in the group, and much condemnation of the members' adversaries outside the group." By the close of session twelve, group members were making strides and great endeavors to move ahead. Since the members did not agree on all things, there was a constant reassessing of goals and norms established by the group. Of course, this created a certain amount of friction. Overall though, the group was creative in defining their goals and settling their differences.

Termination. Finally, because of the investigator's sudden transfer to a new position, it was necessary to begin the termination process by session thirteen. It was clear, however, that the group would continue because of its own strength and leadership. As group leader, it was important to let the group know in a straight forward manner about the move to another life event. It was, also, necessary to assure them of the many positive experiences shared during

the past group meetings. By honestly presenting the facts of the situation, the investigator was able to point out that the coming separation was not related to student placement change or disenchantment within the nursing home. Rather, the move was related to a new growth experience for the investigator.

In response to the presentation given, many questions were asked about arrangements for leaving the group and continuation of group work. It was at this time alternative arrangements for group continuation was suggested. Mr. L. suggested a head nurse, who all members were fond of, and who would be an excellent group facilitator. The possibility of the investigator's return to the nursing home on a bi-weekly basis for several months also provided continuity for the group.

The most positive aspect of this meeting was that members were willing to deal with the issue in a direct manner, looking for other options available to them. It was evident that they were not ready to dissolve the group, but rather preferred to seek recruitment for a new group leader to continue with group work. The group members actually made the decision to go through with a natural separation and move on to other experiences.

Business during session fourteen went on in the usual manner, with the reading of minutes and the treasury report. A barbecue dinner was discussed, along with security issues

and fund raising. However, before the session ended the investigator again referred to the butcher paper that was taped to the conference room back wall. Written on the paper was each group member's name, along with a few words that best described each member's contribution to the group and to the nursing home community. It was important to let the group members know how special they really were in this life. In addition, other members were asked to contribute a few words of appreciation for their fellow members. By allowing each member to demonstrate affection and appreciation toward one another, it was not hard to realize how much experience and opportunity had been gained over a short period of time. With so much "gained," it was difficult to focus on "loss."

Group Feelings

Whenever there is interaction between members there will be certain feelings generated. In this section those special moments experienced by the group or by several group members are highlighted for insight. Some of these moments have already been discussed in previous sections on group work.

Sadness was one of the first emotions demonstrated by the group in session one. As mentioned previously, when Mr. M. became tearful in describing the persecution of the Jews and his family's immigration to America, there was deep emotion felt by all group members. The group became extremely silent and Mr. G., in an attempt to ease the pain, suggested

that the group focus on the "here and now" for the following sessions. Even though Mr. G. might have felt uncomfortable for the first session, it proved to be a test to see how the group accepted Mr. M.'s emotional feelings. As it turned out, there were not really any strong repercussions from the group and members were able to gain a feeling of safety. In other words, Mr. M. opened the door for the expression of honest feelings.

Anger presented itself on two distinct occasions during the group's existence. In session five there was a full house with thirteen members, including three visitors. Many of the regular members expressed concern about some of the nursing home's limitations (as previously cited). Mr. L. requested transportation access to the nursing home. Mr. M. expressed feelings that he had been treated like a child by ward staff because of his disabilities. Mrs. H. wanted to know why the nursing home did not have a volunteer program. One by one, each member described some personal concern.

Towards the end of the group, one visibly shaken visitor stated he was tired of the complaints and quickly left the room. Mrs. L., at one point, stated she too had heard enough and slapped her hand on Mr. L.'s knee to quiet him. These incidents were probably the most illustrative of the frustration and anger that was clearly visible during this meeting.

Even though this particular session provided an outlet for angry, pent-up feelings, it was also evident that residents had difficulty expressing their own personal needs. Basically, they were people who felt powerless and were hesitant to express their concerns for fear of repercussion from nursing home staff. This session was important in that they were allowed to express these feelings without retaliation. They, therefore, became more powerful and secure in their knowledge that it was acceptable to disagree.

The second incident that comes to mind was not so much a feeling of anger, but rather a feeling of irritation and annoyance. Mr. F. had invited Mr. V., a guest, to the group for one particular session when the group was planning a boat trip. As session ten progressed, however, and plans were being made for a San Francisco boat cruise, Mr. V. made several comments about not being able to go on trips because of his leg amputation. About midway through the session, Mr. G. was not able to contain his frustration any longer. In a very matter of fact way he stated, "As you can see we all have disabilities, but you don't see that stopping us from going on a boat trip. You can't mope around forever."

This may have seemed harsh and cruel, but this group did not function on self-pity. Since Mr. V. was renowned for complaining about his physical limitation, this was probably exactly what he was needing to hear. Up until this time, no one had been brave enough to tell him. It was,

therefore, a great surprise to ward staff when Mr. V. returned from this session announcing he was going on a boat trip (the first activity he agreed to join).

Finally, genuine warmth and happiness was expressed during the Valentine's Day dinner, the group's second major social function. Even though nursing home residents were active during group meetings, their activity was not comparable to the excitement they exhibited during dinner festivities. It was significant in that it allowed for holiday memories to surface, recreating spirit and festivity.

The social dinners were usually an all day event, with the preparation of the meal in the nursing home kitchen. This enabled group members to move in and out of the room as they once did in their own kitchens. In addition, the men especially liked to come by and sit around the table and chat while the food was baking. Occasionally they would even volunteer to assist in the kitchen. Mr. F., for instance, liked to stay to arrange the tablecloth and set the table. For the Valentine's Day dinner, soft background music was played and table arrangements included red roses, red wine, and red heart-shaped name plates.

The dinner was not a meaningless event. The entire meal reinforced social skills that were no longer valued in a nursing home setting. For instance, passing serving trays, dressing appropriately for company, and communicating with fellow residents were just a few of the skills needed

to attend this social event. Generally, in day to day life for the nursing home residents, these skills were useless and often forgotten. Residents, in a sense, were given a chance to entertain family members and friends, permitting them the opportunity and privilege to introduce their loved ones.

Problems and Intervention Techniques

Involvement versus passivity. To make the meeting an integral part of each member's life, it was important to provide visual stimulation. To meet this need, poster paper was used as an effective intervention technique. Not only were informational facts written on poster paper, but group plans, poems, and emotional feelings were also recorded. The poster paper provided a focal point for almost every meeting, creating involvement and interest. In planning, for instance, it was a means for some of the senior citizens to conceptualize a dinner, outing, or boat trip, thereby easing anxieties about what was happening around them.

In organizing the group's barbecue (the third group dinner), it was less difficult for members to grasp the planning stage when it was written on paper in full view, with complete group involvement. As tasks, supplies, and last minute preparations were listed for a successful dinner, group members' offered suggestions and volunteered assistance. Mr. A., our treasurer, quickly assessed the treasury and our

monetary needs, ensuring there would be enough on hand to pay for the event. Mr. G., a frequent contributor of food supplies, made suggestions for the meal based on his ability to locate contributors who were willing to donate their goods. Cakes, stuffed turkey breasts, and flowers were just a few of the prizes contributed to our dinners based on his salesmanship! Mr. L. usually volunteered to bring a tape recorder to record some of the group events. What seemed significant was that everyone wanted to make sure his name and contribution was recorded on paper. It is without a doubt, that many of the group's plans might not have worked out quite so well if the group members had not "contracted" on paper.

Autonomy versus dependency. Coplon and Strull (1983:263) write, "Groups are prepared for separation from the time of the initial meeting and although there may be appropriate sadness, groups are able to function sucessfully on their own due to the close ties and easy sharing among members." In terms of the nursing home group, it is hard to determine the exact moment the group became more independent and the investigator less influential. This is probably because the process was gradual and the events took place over a course of many weeks. Once members were electing officers, by the eighth session, it was an obvious time to allow the group to function independently. By giving up a strong leadership role, the group was able to gain necessary autonomy.

Even though the investigator was slowly pulling away, allowing the group to grow, there was still a need for advice on important issues of process, content, assessment, and restoration of smoother functioning. In session ten, for example, there was much discussion about whether to bring "patient congress" to the nursing home group, where residents could voice their concerns about nursing home practices to elected group members. Mr. G. and Mr. L. were in favor of such an action. However, the investigator suggested to the group that even though their concerns were real and required full consideration from nursing staff, fusing "patient congress" with the nursing home group would probably have an overall negative effect. Such an action might turn the group into a complaint forum. Afterall, if "patient congress" already existed on Wednesday mornings, why was it necessary to turn the Friday group into another one?

Apparently, the investigator's opinion still carried some weight. The group voted on the proposal and decided against having "patient congress" as part of the nursing home group. Mr. L., after listening to the arguments, was in full agreement with the final decision. Mr. G. was disappointed, but felt it was a group's decision and accepted the outcome. Overall, even the investigator was able to contribute to the meetings, as the other members, since it was the group vote that enabled the "group-as-a-whole" to remain independent.

Positive reinforcement versus poor self-esteem. Finally, activities and group tasks were essential for the continuation of this group. Activities, such as dinners, boating trips, films, and guest speakers, increased social skills and community involvement. Activities were not passive entertainment spots in the lives of these residents. They were an integral part of reinforcement of positive attitudes and increased self-esteem. Activities enabled members to become active participants in life, rather than passive viewers.

Group tasks were, also, beneficial in that they created group membership importance. Mr. F., for instance, enjoyed cleanup after group meetings and within time, preformed this role weekly. Mr. O. always bought the refreshments for the group. An hour before group meeting he would go to the canteen, in his wheelchair, and pick out the treats for that day. Of course, this meant he needed to contact Mr. A., our treasurer, to obtain the funds, giving Mr. A. special recognition. Mr. L., our chairperson, was always important because of his special gift of leadership. The list of group tasks is endless because as time moved on special roles evolved for each group member. Again, it gave them needed responsibility, self-worth, and "work" that was clearly missing in their lives.

Conclusion

In conclusion, the investigator's opportunity as a group leader of the nursing home group was a very rewarding

experience. There is, however, some anxiety associated with every new group work experience. As a new social worker in the nursing home, it was somewhat difficult leading the only elderly group organized within the nursing home. Every conceivable problem was visualized including membership drop out, quiet sessions, and staff resistance. However, even though there were members who dropped from the group there were many more residents who joined to replace them. New faces were always present in group meetings, sparking curiosity and fresh new ideas. In addition, from the very outset of group formation, there was little boredom or disinterest during sessions.

Staff resistance, however, proved to be a somewhat difficult problem. As an example, there were times when nursing staff knowingly scheduled residents' medical appointments during group hours, even though they had clearly been informed of the meetings each week. Staff resistance was, also, exhibited when 10 a.m. meetings began and group members were missing because they had not been bathed or dressed. These incidents were not just coincidental. It was more than coincidence that group members were bathed and dressed early every day of the week except Friday. However, this resistance only spurred the investigator's determination.

Rather than becoming angry, the investigator felt it was more important to meet with staff personnel each Friday morning, during staff meetings, to remind them of the nursing

home group. This seemed to subside staff resistance, especially when there was a sharing of group happenings. Several nurses even commented that they too wished they could provide more personal care for the nursing home residents. However, due to the fact that medications needed to be dispensed, reports required completion, and residents had to have their basic needs taken care of, there was little time for special attention and recreational activities. Fortunately, this sharing enabled the investigator to better understand staff attitude and resistance. Direct involvement with the residents, during the exciting and fun events in the nursing home, left little or no time for the investigator to argue with residents over their medications, eating habits or any other number of incidents that could have hampered positive relationships.

This is not to say that all staff members resisted group work. Actually, there were many staff personnel who showed a genuine interest in the group and went out of their way to provide transportation or make whatever arrangements were necessary for a successful group event. When the San Francisco boat cruise was organized, for instance, it was a delight to learn that three nursing staff members volunteered to push wheelchairs during the excursion. Their assistance actually made the event a success.

To be a group leader for an elderly group is a challenge. Initiating and encouraging enthusiasm is not an easy task in a nursing home environment, where senior citizens literally

are only going through the motions of life. Many of these people have experienced so many losses that there is a tendency to give-up. An an example, several group members were unwilling to contribute to the meetings during the first few sessions, as if they were testing to see if the group would actually continue. One can quickly understand this behavior in light of the fact that within the nursing home environment many residents die and staff personnel change almost weekly. Consistency in group work, therefore, is extremely important in providing an atmosphere of trust and continuity.

Another important factor in leading a group of elderly residents, who are high functioning individuals, is allowing for group and individual independence. Independence, afterall, is fostered in an environment of trust and respect. Unfortunately, residents are often spoken to in a childlike manner, with total disregard of their knowledge and well-being. Respecting senior citizens, with their vast years of experience, not only benefits the elderly, but those around them who learn from their experiences. The "Friendly Group" honored this knowledge by adding group member's ages during one of the sessions. What a surprise to discover that a total of 862 years of accumulated knowledge contributed to the group meetings! This most certainly deserves some respect.

Overall, nursing home group work is satisfying and challenging for any individual who cares for the elderly and wishes to contribute to the betterment of their last years

on earth. This really is the most important part of leading a senior citizen group. The experience is rewarding because, as in any helping relationship, the helper is the one who truly comes out ahead.

CHAPTER 4

Research Methodology

Major Research Design

The basic research design of this study was an evaluation research. William B. Sanders (1983:387) states, "Since the primary purpose of evaluation research is to determine the effectiveness and efficiency of a program, the focus is on whether or not the procedures have been implemented and, if put to work, can achieve a set of goals stated by the program." Even though the object of study was not a program, but rather the effects of group process, the evaluation research design seemed to be the most beneficial as a guide for this research project. The challenge and innovation in anticipating patient needs and providing a format to deal with them, in a genuine manner, can only be measured through evaluation research.

The one group, pretest - posttest method was used to evaluate the effectiveness of the group. A control group was not used in this study; however, it was still a valuable experiment. Since it was the investigator's first study involving a skilled nursing home activity group, much insight and information was gained through evaluation of group process and dynamics.

In addition to the evaluative research design, a descriptive design format assisted in outlining the interactions

that occurred in each group meeting. According to John Best (1959), descriptive research involves the description, recording, analysis, and interpretation of the present nature, composition, or processes of phenomena. For the purpose of this study, the investigator recorded how group members interacted with one another, within the group, and the significance of these interactions. Behavior, in otherwords, was viewed over a period of time during the life of the group. Evaluation and descriptive research provided the means of gathering data for this analysis.

Study Sample and Sampling Methods

The Nursing Home Care Unit is a 150 bed unit located in a modern building at the Menlo Park Division of Palo Alto Veterans Administration Medical Center. In the investigator's study, twenty psychosocial assessments, found in medical charts, were evaluated from a total population of 150 patients residing in the nursing home. In formulating the sample frame, the following criteria was used for including residents into the elder group: (1) mobility (including wheelchair residents), (2) verbal ability, (3) coherence, and (4) ability to sit for one hour weekly. There was no restricted age limitation and both men and women were able to partake in the group.

It was a most difficult process to weigh all the considerations in selecting group members. In deciding who would

be in the group, capabilities, personalities, and similar needs had to be considered. Additional factors, such as hearing loss, mental impairment, physical disability (ambulatory or wheelchair bound), and visual impairment were other criteria that needed careful attention. To obtain a mixture of group members that create vitality and yet maintain stability is not an easy task!

The open group format was the most appropriate for this nursing home elderly group, since group stability was maintained by replacing members who left the group. An open group format, according to Yalom (1977:277), may "continue indefinitely, even though every couple of years there may be a complete turnover of group membership and even of leadership." Generally, six to eight members is the average range for maximum group effectiveness. However, for a beginning elder group, eight to twelve is ideal because of the high potential dropout rate. This small group size encourages cohesiveness, where group members have the opportunity to make a real contribution to the group, express opinions, and receive recognition for that contribution.

Research Instruments

The research instruments that were used in this study include the following three questionnaires: (1) Brief Symptom Inventory (Derogates, 1981), (2) Mood Assessment Scale (Yesavage and Brink, 1981), and (3) Morale Quality Scale

(developed through Depression for Elderly Project). The combined questionnaires include a total of ninety-two questions, developed through the Depression for Elderly Project at the Menlo Park Division of Veterans Administration Medical Center, Palo Alto, California. The questionnaires were developed to define and assess senior citizen depression and some of the various dimensions of depression (such as hopelessness, poor self-esteem, and lack of energy).

The data from the questionnaires is useful in determining whether an activity group enhances the psychosocial functioning of nursing home group members. Depression is one variable that is used as an indicator in measuring psychosocial functioning. A description and several sample questions of each questionnaire is given below.

Brief symptom inventory scale. The Brief Symptom Inventory Scale (see Appendix B) is a questionnaire that has the advantage of being easily administered, as well as being easily understood by the respondents. This scale is a frequently used scale that has been well researched and found quite appropriate as a research tool. It was designed with ten original scales, which provide a psychological or mood profile of the respondent tested.

The ten subscales of the questionnaire are measured separately and are appropriately categorized as somatization, depression, phobic anxiety, obsessive-compulsive, anxiety,

paranoid ideation, internal sensitivity, hostility, psychoticism, and additional items. Basically, respondents are rated on the problems they sometimes have in their daily lives and the amount of discomfort these problems produce. Sample problems and complaints might include feelings of ending one's life, feeling lonely or inferior to others, and possible experiencing irritability.

Mood assessment scale. The Mood Assessment Scale (see Appendix C) is a questionnaire that was developed by two Veterans Administration researchers at the Palo Alto Division Veterans Administration Medical Center. This scale measures the intensity of depression from a range of normal to severely depressed. It was chosen because of its popularity and earned respect by hospital staff.

Morale quality scale. The Morale Quality Scale (see Appendix D) is a scale that was also developed through the Depression for Elderly Project at Veterans Administration Medical Center. This scale measures the intensity of morale with a range of zero to nine points, nine points equivalent to a very high morale. This questionnaire includes questions that ask the respondent how things are going for him personally.

All three questionnaires were completed in a private individual interview with each group member prior to the beginning of the nursing home group formation. The scales were again administered following fourteen weeks of group

sessions. The individual group members were requested to reveal honest answers during pretest and posttest interviews. The approximate time for completion of each interview was one hour. At the beginning of each interview there was an introduction, with the investigator stating the purpose for the study and informing group members that their names would be withheld from the study.

At the completion of the posttest, respondents were asked how they liked the group. From this the investigator was able to get some subjective feedback about the group and those participating in it. In addition, while group meetings were in session, the investigator closely monitored group behavior and individual attitude, such as attendance, member interaction, and overall participation.

CHAPTER 5

Research Organization and Other Content

Research Organization

There is an important service provided for the aging and chronically ill veterans and their families at the Veterans Administration, Menlo Park Division, Nursing Home Care Unit. The Nursing Home Care Unit, opened in June 1979, provides a range of skilled nursing programs, including physical and occupational therapy programs to elderly veterans throughout California. The nursing home, consisting of 150 beds, is arranged into three community pods (gold, blue, and red) where there is a supportive and warm environment established for the residents and family members who visit.

There are, also, two innovative programs that have developed within the nursing home - the hospice and respite programs. Both of these programs are designed to assist the elderly veteran's family in providing home care for as long as possible. The hospice program provides inpatient and outpatient services to the terminally ill patient and his family. Services include home visits by staff members, delivery of equipment, such as wheelchairs, and inpatient terminal care. The respite program, on the other hand, assists the chronically ill veteran and his family, by providing temporary inpatient care (five to seven days) for the elderly resident. In this

way, the caregiver receives relief from ongoing care given to the patient at home.

The majority of residents within the nursing home, however, are elderly people who require long term care services and live in the nursing home for the remainder of their lives. The long-term care resident receives the full range of services available at the nursing home. In addition, these veterans are afforded around-the-clock care from physicians and nursing staff alike. In conclusion, the nursing home seeks to serve their residents with the most innovative and compassionate care available. With the dedicated staff now in existence, this goal is a reality.

Limitations of study

There are several limitations in conducting a study of an elderly group within a skilled nursing home facility. First, the size of the sample population is relatively small, only a small percent of the total population of nursing home residents. Therefore, the information gathered from this particular study cannot be as accurate if generalized to include a larger population of elderly residents within the nursing home or at other nursing homes within the community.

Second, this study was conducted over a period of five months at the nursing home, giving the residents an opportunity to talk to each other in the nursing home regarding the questionnaires (between the pretest and posttest). Thus,

it is possible that biased answers were given by those residents who were interviewed in the posttest. Because of greater test experience, people often do better in the second test (Simon, 1969). Answers given to the questionnaire in the posttest might not, therefore, represent a fair or accurate picture of the "true" feelings a nursing home resident would be feeling.

Finally, many changes can occur over time regardless of special events. In working with any group, changes may occur between the pretest and posttest because of maturation. Elderly residents, oftentimes, change their attitudes and positions on many issues over the passage of time, with or without group intervention. To further complicate the matter, there are, also, inconsistencies among nursing home residents regarding their length of stay in the nursing home. Therefore, the varying lengths of stay and changes that occur during residency influence the answers given to the questionnaires.

Implications for Social Work

Nursing home residents are individuals who must be cared for physically and emotionally. Since these individuals have experienced so many losses in their lives, they require more than the usual methods in dealing with the challenges of continued living. This proposed study intends to highlight the emotional challenges facing these nursing home

residents and contribute significantly to insights of their numerous and multifaceted problems. Too often in the past group work has been undefined and lumped together, giving shallow information as to what type of group is most helpful to the diversified nursing home population. Studies, such as this, are vital in working with the elderly, in light of the trend toward an older general population. Methods must be devised, utilizing individual strength and wisdom of the members of the nursing home, to restore self-confidence and allow for continued functioning during times of stress for the nursing home resident. Information derived from this study benefits both nursing staff and social work staff in identifying the concerns and needs of residents living in the nursing home environment.

CHAPTER 6

Findings and Interpretations

Demographic Characteristics

Three questionnaires were completed in the pretest and posttest by each of the eight regular members of the nursing home "Friendly Group" (see Chapter 4, research instruments section). The ages of the respondents ranged from 42 to 90 years of age, with the mean age of 74 years. The sample consisted of three females and five male group members. There was one married couple in the sample, but they were counted as separate single respondents. Of the six remaining respondents, three members were widowed, one member was divorced and the other member was single. The final member was married, but living apart from his wife. The overall mean length of stay at the Menlo Park nursing home was sixteen months. All respondents in the sample were of Anglo-American origin.

A total of ten residents started the group, but three members dropped out prematurely and were not included in the final analysis. Of the three group members who dropped out of the group, one member quit because of nervousness, one because of health failure requiring hospitalization, and the third member complained of a hearing loss and inability to follow conversations.

During the course of a total of 14 group sessions, new additional members were added to the original group of seven, bringing the group membership to a total of 16 members. However, of this total only eight members completed a full 12 sessions, with consistent attendance throughout the observation period (one criteria for inclusion in the final analysis). The other group members had sporadic attendance or entered the group so late in its progression, that a total of 12 sessions could not be completed.

Frequency Distribution of the Sample Responses

One of the main purposes for the pretest and posttest questionnaires was to discover whether a nursing home activity group would, in fact, lead to significant improvement in the nursing home residents' psychosocial functioning within the usual nursing home setting. Tables two through six summarize the pretest and posttest responses for this sample group on each of the questionnaires.

Brief symptom inventory scale. The differences between the pretest sample group and posttest sample group mean scores, on the Brief Symptom Inventory, were evaluated with a dependent group t-test. It was found the group differed markedly between the pretest and posttest, though their deviation was not significant at the .05 level. The dependent group t-test produced means and standard deviations which showed no

significant difference for any of the ten subscales, except for hostility. The data is presented in Table 2.

Table 2

Comparison of Pretest and Posttest Means for B.S.I.

	B.S.I. Sample Group		
Subscale	Pre	Post	t-ratio
Somatization	4.87	4.50	.41
Depression	5.25	3.12	1.33
Phobic Anxiety	2.50	1.62	1.05
Obsessive-Compulsive	5.87	5.87	0
Anxiety	4.12	3.25	1.31
Paranoid Ideation	2.12	1.37	1.66
Internal Sensitivity	2.75	2.62	.11
Hostility	2.25	.75	2.81
Psychoticism	2.37	2.50	-.23
Additional Items	3.25	2.50	1.21

Note: Positive t's indicate improvement on B.S.I.

Overall, even though there is proportionally greater improvement among the sample group posttest means, the only significant difference appears to be in the area of hostility. This significance may be attributed to the form of self= government that developed within the nursing home group over

the course of 14 weeks. As group members became more vocal about their concerns within the nursing home and shared their personal frustrations, there was a reduction in anger and hostility that previously had not been expressed.

It is, also, interesting to note that there was an inverse relationship with the pretest and posttest subscale, psychoticism. It is difficult to understand the reason for the increase in psychotic symptoms, outside of the fact, that as weeks went by and the investigator became more familiar with the residents, they were able to share their innermost feelings. As individual group members, they developed a bond of acceptance and fears of disapproval and ostracism dissipated. Therefore, perhaps more honest answers were given to the investigator during the posttest.

The obsessive-compulsive subscale remained constant for the pretest and posttest, showing the highest mean scores of all Brief Symptom Inventory scales. There was, also, little change in mean scores with the somatization and internal sensitivity subscales.

Mood assessment scale. The results from the Mood Assessment Scale were analyzed with a simple matched-pair t-test which showed no significant difference for the subscale depression. Once again the mean score for the posttest reveals improvement for the subscale depression, but the deviation is not significant, even though there is a slight

reduction of depressive symptoms. The results are presented in Table 3.

Table 3

Mood Assessment Scale Mean Score Comparison

Respondents	Pretest	Posttest
Mr. O	17	23
Mr. A	13	7
Mr. G	5	8
Mr. L	10	6
Mr. F	19	11
Mrs. H	11	7
Mrs. M	14	15
Mrs. L	11	8
Total Mean Score	12.50	10.62

Note: $S_D = 4.76$ and t-ratio $= 1.11$

Table 4 shows the distribution of scores on the Mood Assessment Scale. Basically, scores of zero to nine indicate a normal amount of depression, ten through nineteen a mild depression and twenty through thirty a severe depression. The mean scores on the pretest and posttest for this item indicates a slightly mild depression within this sample group. Only one group member, Mr. O., suffered from severe

depression and this was in the posttest figures. It is interesting to note that while 87.5% of the group members suffered from mild depression in the pre-test and prior to group sessions, only 25% of the group members in the post-test suffered from mild depressive symptoms.

Table 4

Intensity of Depression

Intensity	Scale Score	Pretest	Posttest
Severe	20-30		1
Mild	10-19	7	2
Normal	0-9	1	5

Morale quality scale. A comparison between the pretest mean score and posttest mean score shows there was no improvement in morale for this sample group. A dependent t-test produced means and standard deviations which showed no significant difference.

Group morale did not increase over the 14 week period of group work. However, it is interesting to note, particularly, that Mrs. M. and Mr. F., two members whose scores greatly decreased in the posttest, died shortly after the close of group sessions. It would seem, therefore, that their enthusiasm, willingness and courage was at a low point during posttest questioning. The data is presented in Table 5.

Table 5

Morale Quality Mean
Score Comparison

Respondents	Pretest	Posttest
Mr. O	8	8
Mr. A	3	4
Mr. G	1	1
Mr. L	4	3
Mr. F	4	7
Mrs. H	3	3
Mrs. M	3	8
Mrs. L	5	4
Total Mean Score	3.87	4.75

Note: S_D = 2.10 and t-ratio = -1.18

Table 6 reveals the distribution of scores on the subscale of Morale. Morale intensity decreases as the scale score increases. Therefore, scores of two and three indicate high morale, while scores above four indicate low morale. As shown, the mean scores of the pretest and posttest reveal a sample group of nursing home residents with an average to low morale profile. However, as previously mentioned, two group members were primarily responsible for lowering the morale score in the posttest figures.

Table 6

Morale Intensity

Intensity	Scale Score	Pretest	Posttest
Low	8	1	2
Morale	7		1
	6		
Average	5	1	
Morale	4	2	2
	3	3	2
High	2		
Morale	1	1	1

The reader should note that on the three questionnaires there was an overall improvement in the psychological - mood profiles of the nursing home group members. Depression and particularly, hostility, were two areas that group members showed improvement. However, even though improvement was not demonstrated to be significant, except for in the area of hostility, this does not necessarily mean that group work had no value within the nursing home environment. Quite the contrary, the group made possible, through its organization, a distinct self-help culture that provided acceptance, accomplishment, and involvement.

The elderly nursing home group evolved into a self-help

group with recreational activities actually fulfilling some of the group's functions. Goals emerged from the group rather than being applied to it by the group leader or other outside resources. These goals were realized through peer sharing, since members shared the mutuality of the problems. While group members worked for the good of the entire group, they gained in individual achievement and self-esteem. The group worked toward making the nursing home a better place to live, and actually was successful in this endeavor.

Even though this progressive nursing home was less restrictive toward the nursing home residents, in comparison to other nursing homes, the environment was still somewhat depressing. It is the investigator's belief that the group instilled a "spirit of independence" among group members that permeated throughout the nursing home. This spirit was reflected in the dinner activities, outings, group assignments, and orientation program that developed after the group was formed. Group members became more vocal and were willing to confront their daily problems. Ward staff became more respectful of the residents as a group and seemed to listen when more than one resident presented a problem. More than several staff members commented on the positive influences that the "Friendly Social Group" had on nursing home residents and their family members. The effective method of group work, as a way to deal with the problems of a stifling nursing home environment, simply cannot be underestimated.

Chapter 7

Conclusion

The true value of the "Friendly Social Group" was reflected in the improved nursing home environment. When the "quality" of life became a priority, the group members and staff personnel responded. Within a few short months the senior citizen group developed into an effective natural support system. Nursing staff personnel, volunteers, administrators, and service workers were, in one way or another, influenced by the group's strength. Conflict, in the context of group work, provided impetus and served as a catalyst for productive and powerful change. Rather than anger being displayed in a destructive striking out manner, it was redirected into a strong yet solid force for empowerment. The mutual-aid system that developed encouraged personal growth through environmental change.

The changes exhibited by the nursing home residents were revealed in the Brief Symptom Inventory and Mood Assessment Scale posttests. Hostility, which was allowed to emerge and reveal the true frustrations the group members were experiencing in their environment, was significantly reduced in the Brief Symptom Inventory Scale posttest. In addition, as the group became more involved, they were able to channel their aggression and modify their anger through group

activities directed toward nursing home policy changes. Also, and not insignificantly, the residents were able to receive group and staff support for their efforts. These factors combined validate the elderly group as a useful and therapeutic intervention for structural change and problem-solving.

Overall, the group's goals and objectives were achieved. A mutual-aid system developed that allowed new ideas to be shared, activities initiated, and valuable information gained. An atmosphere of trust, acceptance, and understanding grew over a short period of time, and prevailed even during times of misunderstanding and disagreement. Activities and social events especially played a significant part in the development of this supportive atmosphere. They were the vehicle whereby group members gained a real sense of belonging, meeting one of man's basic needs for love and affiliation.

Without a doubt, the group's ability to gain independence was one of its most successful accomplishments. In achieving a sense of independence, members were able to gain some control over their environment. This was a real accomplishment considering the losses many of these elderly residents experienced during their nursing home stay. Most of these residents had lost control over the most simplest of tasks, such as planning their meals or choosing their wardrobe. Having an opportunity to voice their concerns was extremely valuable in increasing autonomy and self-worth. The group

challenged the notion that depression and inactivity is an expected consequence of living within a nursing home environment. Over time they demonstrated the value of an active life with involvement, free choice, and autonomy.

This is not to say that all nursing home residents benefit from a mutual-aid group experience. However, for high functioning residents who are alert, oriented, able to care for their personal needs, and are without severe disability, the autonomous, mutual-aid type of group seems to be the most beneficial. There are a variety of group techniques that can be used to support and assist the elderly in coping with the nursing home environment. Studies, however, are limited and more information is needed to address senior citizens and their multifaceted problems. Most studies are descriptive and consider nursing home residents homogenous and therapy universal, without allowing for individual differences.

In understanding and recognizing the importance of mutual-aid groups within the institution, the investigator recommends for future research the exploration of different research instruments for measuring group and staff attitudes. Rather than focusing on psychological symptomatology, as this study did, questions should be directed toward the nursing staff, administrators, and group members regarding social and environmental changes within the institution. It might also be of interest to conduct a follow-up study with a larger

sampling frame, examining the role of group leader. There is a growing need for further in-depth studies that explore the issues of group work within institutions and the kinds of leadership needed to promote personal growth.

In conclusion, this study demonstrates the importance of group activities in promoting independence, autonomy, and successful problem-solving. Senior citizen groups strengthen, not only the group members, but other associations including the family system, formal institution, and larger community. By strengthening and empowering group members, there is real meaning given to the idea that social workers "help members to help themselves." It is apparent that through group work the quality of life can be enhanced and better understood.

Appendix A

Nursing Home Orientation Book

WELCOME!

THE NURSING HOME CARE UNIT EXTENDS A CORDIAL WELCOME TO:

____

YOU LIVE ON THE __________POD, 331________

YOUR DOCTOR IS ________________________EXT.__________

YOUR HEAD NURSE IS ____________________EXT.__________

YOUR SOCIAL WORKER IS _________________EXT.__________

YOUR WARD CLERK IS ____________________EXT.__________

THE PAY TELEPHONE NUMBER IN YOUR AREA IS _____________

THE NURSING HOME BUSINESS HOURS ARE 7:30 TO 4:30 P.M.

MONDAY THROUGH FRIDAY

(415) 493-5000 EXTENSION 2244

<u>OPEN VISITING HOURS</u>

I N D E X

	PAGE
CANTEEN	5
CHAPLAIN SERVICES	4
CLOTHING & PERSONAL ITEMS (LAUNDRY)	2
DAY PROGRAM	5
FUNDS	1
LIBRARY SERVICES	4
MAIL	1
MAPS	6
NUTRITION	4
OUTINGS	4
GENERAL INFORMATION	1
PHYSICIANS	3
PUB	5
RECREATION SERVICE	5
REHABILITATION SERVICES	3
SOCIAL WORKERS	3
TELEPHONE CALLS	1
VISITING HOURS	1

INTRODUCTION

IN THIS BOOKLET, YOU WILL FIND SOME GENERAL INFORMATION ABOUT YOUR UNIT, THE TREATMENTS YOU MAY RECEIVE AND THE PROGRAMS, ACTIVITIES AND SERVICE AVAILABLE TO YOU IN THE NURSING HOME CARE UNIT. WE HOPE THIS BOOKLET ANSWERS SOME OF YOUR QUESTIONS AND HELPS YOU TO BECOME ACQUAINTED WITH US.

WE ARE A 150 BED NURSING HOME DIVIDED INTO THREE UNITS, OR PODS, OF 50 BEDS EACH. MOST OF OUR RESIDENTS SHARE A ROOM WITH ONE OTHER PERSON. THEY ARE ADMITTED AFTER A SCREENING TO DETERMINE V.A. ELIGIBILITY AND APPROPRIATENESS FOR THE SETTING. WE ADMIT FOR BOTH SHORT AND LONG TERM STAYS.

GOLD POD (331-B) HAS 42 PERMANENT RESIDENTS IN ADDITION TO AN EIGHT BED RESPITE PROGRAM. THE RESPITE PROGRAM PROVIDES PERIODIC RELIEF FOR THE FAMILIES OF CHRONICALLY ILL VETERANS WHO LIVE IN THEIR OWN HOMES.

RED POD (331-C) HAS 45 PERMANENT RESIDENTS IN ADDITION TO A FIVE BED INPATIENT HOSPICE UNIT. THE HOSPICE PROGRAM PROVIDES INPATIENT AND OUTPATIENT SUPPORT AND TREATMENT FOR TERMINALLY ILL VETERANS WHO LIVE IN THEIR OWN HOMES.

BLUE POD (331-D) HAS FIFTY PERMANENT RESIDENTS.

A MULTIDISCIPLINARY TEAM, INCLUDING THE NURSING HOME SUPERVISOR, PHYSICIAN, HEAD NURSE, NURSING STAFF, SOCIAL WORKER, DIETICIAN, PUBLIC HEALTH NURSE, NURSE GERONTOLOGIST, OCCUPATIONAL THERAPIST, PHYSICAL THERAPIST AND RECREATION

SPECIALISTS WORK TOGETHER TO CREATE THE BEST POSSIBLE ENVIRONMENT TO MEET THE FAMILY AND VETERAN'S NEEDS. THE TEAM MEETS ON A REGULAR BASIS TO DISCUSS THE MEDICAL AND SOCIAL PROGRESS NEEDS AND GOALS OF EACH RESIDENT AND MAY INVITE YOU TO ATTEND OUR TEAM CONFERENCE. WE HOPE TO SEE FAMILY AND FRIENDS IN THE NURSING HOME CARE UNIT AS OFTEN AS POSSIBLE AND LOOK FORWARD TO YOUR HELP IN MAKING THE VETERAN'S STAY AS PLEASANT AND COMFORTABLE AS POSSIBLE.

GENERAL INFORMATION

VISITING AND CALLING

VISITING HOURS ARE OPEN, BUT WE WOULD PREFER THAT YOU VISIT BETWEEN THE HOURS OF 11 A.M. AND 8 P.M., UNLESS THERE ARE UNUSUAL CIRCUMSTANCES. YOU MAY TELEPHONE ANYTIME TO INQUIRE ABOUT YOUR FAMILY MEMBER. IF YOU WISH TO TALK TO A RESIDENT DIRECTLY, PLEASE USE THE PAY TELEPHONE NUMBER. IF YOUR FAMILY MEMBER IS NOT AMBULATORY, WE CAN TAKE A TELEPHONE TO THE BEDSIDE. MANY OF OUR RESIDENTS HAVE HAD PRIVATE PHONES INSTALLED IN THEIR ROOMS AND YOU MAY WISH TO ARRANGE THIS THROUGH THE TELEPHONE COMPANY.

MAIL

MAIL IS PICKED UP AND DELIVERED TWICE A DAY. IF A RESIDENT IS UNABLE TO READ HIS MAIL, LETTERS ARE OPENED AND READ TO HIM BY A STAFF MEMBER OR A VOLUNTEER WHO WILL ALSO HELP RESIDENTS TO WRITE LETTERS, IF NECESSARY.

WE ENCOURAGE YOU TO SEND CARDS AND LETTERS. THE MAILING ADDRESS IS:

(RESIDENT'S NAME AND POD NUMBER)
V.A. MEDICAL CENTER
NURSING HOME CARE UNIT
3801 MIRANDA AVENUE
PALO ALTO, CA. 94304

FUNDS

RESIDENTS WILL NEED FUNDS FOR HAIRCUTS, TOILETRIES, CLOTHING, OUTINGS AND OTHER PERSONAL EXPENSES. IF YOU HANDLE THE RESIDENT'S MONEY, YOU WILL BE ASKED TO MAKE REGULAR DEPOSITS TO HIS HOSPITAL ACCOUNT. THE CHECK OR MONEY ORDER SHOULD BE MADE OUT TO:

HOSPITAL DIRECTOR
(INDICATE NAME AND SOCIAL SECURITY
NUMBER OF RESIDENT IN WHOSE ACCOUNT
THE MONEY IS TO BE DEPOSITED)

IT SOULD BE MAILED TO:

AGENT CASHIER - MPD
V.A.M.C.
3801 MIRANDA AVENUE
PALO ALTO, CA. 94304

SINCE A PERSONAL CHECK CAN TAKE UP TO 15 DAYS TO CLEAR, IT IS ADVISABLE TO SEND A MONEY ORDER OR CASHIERS CHECK IF THE MONEY IS NEEDED FOR IMMEDIATE USE. CASH CAN ALSO BE DEPOSITED DIRECTLY WITH THE AGENT CASHIER.

CLOTHING & PERSONAL ITEMS

ALL RESIDENTS DRESS IN THEIR OWN CLOTHING, WHENEVER POSSIBLE. THIS SOMETIMES INVOLVES SEVERAL CHANGES OF CLOTHING A DAY. FAMILIES SHOULD SUPPLY ENOUGH CLOTHING TO ALLOW FOR FREQUENT CHANGES AND LAUNDERING WHICH MAY TAKE UP TO THREE WEEKS.

A MALE RESIDENT WILL NEED AT LEAST 14 PAIRS OF WASH AND WEAR TROUSERS, 14 WASH AND WEAR SHIRTS AND SIMILAR AMOUNT OF UNDERCLOTHING. AN EQUIVALENT AMOUNT OF CLOTHING SHOULD BE AVAILABLE FOR EACH WOMAN RESIDENT. WE PROVIDE NIGHT CLOTHES AND SOCKS. EACH RESIDENT SHOULD ALSO HAVE A PAIR OF COMFORTABLE SHOES, SLIP-ON SLIPPERS (NO SCUFFS), A WARM SWEATER AND JACKET FOR OUTDOORS AND APPROPRIATE CLOTHING FOR SPECIAL OCCASIONS. WE ASK EACH MALE RESIDENT TO BRING AN ELECTRIC RAZOR.

THERE IS A WASHER AND DRYER ON THE PREMISES FOR THOSE RESIDENTS WHO ARE ABLE TO AND WHO WISH TO DO THEIR OWN

LAUNDERING, OTHERWISE ARRANGEMENTS CAN BE MADE TO HAVE PERSONAL LAUNDRY DONE FOR A SMALL FEE.

ALL OF OUR VETERANS ARE ENCOURAGED TO BRING IN A FAVORITE ITEM OF FURNITURE, PLANTS AND PICTURES. THE TRANSITION FROM HOME TO A NURSING HOME CAN BE EASED WITH SOME FAMILIAR POSSESSIONS ON HAND. WE ENCOURAGE EACH RESIDENT TO MAKE THEIR ROOM AS HOME-LIKE AS POSSIBLE.

RESIDENTS ARE RESPONSIBLE FOR THEIR OWN JEWELRY, CLOTHING, OTHER VALUABLES AND MONEY.

PHYSICIANS

WE HAVE TWO FULL-TIME PHYSICIANS AS WELL AS OFF-HOUR COVERAGE BY THE MEDICAL OFFICER OF THE DAY.

A COMPLETE PHYSICAL EXAMINATION IS DONE FOR EACH RESIDENT ON ADMISSION AND ANNUALLY. THE PHYSICIANS ARE KEPT AWARE OF EACH RESIDENTS MEDICAL STATUS ON A DAILY BASIS. IF AN ACUTE CONDITION DEVELOPS THE RESIDENT MAY BE SENT TO PALO ALTO DIVISION FOR MORE INTENSIVE MEDICAL CARE.

SOCIAL WORKERS

SOCIAL WORKERS BRIDGE THE GAP BETWEEN COMMUNITY AND NURSING HOME CARE UNIT AND ARE ALSO A SOURCE OF INFORMATION AND REFERRAL FOR BOTH V.A. SERVICES AND COMMUNITY RESOURCES.

THEY PROVIDE SUPPORTIVE COUNSELLING TO RESIDENTS AND FAMILIES AS WELL AS HELP IN CRISIS SITUATIONS. SOCIAL WORKERS ARE ALSO THE PRIMARY STAFF INVOLVED IN HELPING RESIDENTS AND FAMILIES WITH PLANS FOR COMMUNITY PLACEMENTS.

REHABILITATION SERVICE

OUR REHABILITATION STAFF INCLUDES AN OCCUPATIONAL THERAPIST AND A PHYSICAL THERAPIST. ALL ACTIVITIES ARE DESIGNED TO ENCOURAGE FUNCTIONING AT THE MAXIMUM LEVEL POSSIBLE TO MAINTAIN PHYSICAL AND MENTAL ABILITIES. THE GOAL IS TO ENCOURAGE

PERSONAL INTERACTION, SOCIAL AWARENESS AND INDEPENDENCE.

RECREATION SERVICE

WE HAVE TWO RECREATION SPECIALISTS ON STAFF WHO PROVIDE OPPORTUNITIES FOR THERAPEUTIC LEISURE SKILLS IN SOCIAL, EDUCATIONAL AND RECREATIONAL ACTIVITIES. THIS INCLUDES OUTINGS, OVERNIGHT TRIPS, ENTERTAINMENT EVENTS, AS WELL AS INDIVIDUAL PROGRAMS. IN ADDITION, VOLUNTEERS FROM VETERAN SERVICE ORGANIZATIONS COME TO THE NURSING HOME ON A REGULAR BASIS TO PROVIDE RECREATIONAL ACTIVITIES.

OUTINGS

OUTINGS AND VISITS TO HOME ARE ENCOURAGED. LET OUR STAFF KNOW AT LEAST ONE DAY IN ADVANCE IF POSSIBLE, SO THAT WE CAN ORDER ANY SUPPLIES OR MEDICINES THAT THE RESIDENT MAY NEED. THE DOCTOR'S APPROVAL IS NECESSARY BEFORE A RESIDENT CAN GO ON AN OUTING OR VISIT.

NUTRITION

THE DIETICIAN MAKES AN INITIAL VISIT TO EACH NEW RESIDENT TO LEARN HIS OR HER LIKES AND DISLIKES. SHE WORKS CLOSELY WITH MEDICAL AND NURSING STAFF TO ASSESS EACH RESIDENT'S NUTRITIONAL NEEDS AND VISITS EACH RESIDENT PERIODICALLY. THE DIETITIAN WELCOMES INQUIRIES, AT ANY TIME, AND ENCOURAGES RESIDENTS AND FAMILIES TO PARTICIPATE IN MEAL PLANNING. BREAKFAST IS SERVED FROM 7 TO 8 A.M.; LUNCH FROM 11:45 TO 1 P.M.; AND DINNER FROM 4:45 TO 5:45 P.M.

CHAPLAIN SERVICES

CHAPLAINS OF EVERY DENOMINATION ARE AVAILABLE TO PROVIDE SPIRITUAL SUPPORT TO OUR RESIDENTS AND THEIR FAMILIES WHO REQUEST THIS SERVICE. THERE IS A CHAPEL ON THE GROUNDS WITH REGULAR SERVICES SCHEDULED.

LIBRARY SERVICES

THERE IS A GENERAL LIBRARY ON THE GROUNDS. FOR THOSE WHO ARE ABLE TO GO, THE HOURS ARE MONDAY TO FRIDAY FROM 11:30 TO 2:30 P.M. IN BLDG. 103.

THE LIBRARIAN ALSO COMES TO N.H.C.U. EVERY THURSDAY 2:30 TO 4 P.M. AND MAKES EVERY EFFORT TO PROVIDE READING MATERIALS OR TALKING BOOKS TO ACCOMMODATE INDIVIDUAL TASTE. READING MATERIAL IS ALSO AVAILABLE ON EACH POD.

DAY PROGRAM

THE ELDER VETERAN DAY CENTER, ON GROUNDS, PROVIDES A DAY PROGRAM FOR THOSE RESIDENTS WHO CAN BENEFIT FROM ADDITIONAL SOCIAL, RECREATIONAL AND EDUCATIONAL STIMULATION. TO ATTEND, THE RESIDENT MUST BE SCREENED BY THE PHYSICIAN AND ELDER VETERAN DAY CENTER STAFF. IF ACCEPTED, THEY MAY ATTEND FROM ONE TO THREE DAYS A WEEK.

PUB

A PUB IS OPEN FROM 3 P.M. TO 4 P.M. MONDAY TO FRIDAY, IN THE DINING ROOM. THE RESIDENT MAY HAVE A LIMITED AMOUNT OF BEER, WINE, WHISKEY OR SOFT DRINK, IF APPROVED BY THE PHYSICIAN.

THE PUB HOUR IS USED AS A CENTRAL MEETING PLACE FOR RESIDENTS AND FAMILIES. MANY FRIENDSHIPS HAVE BEEN MADE AND MAINTAINED AT THE PUB.

CANTEEN

THERE IS A CANTEEN ON THE PREMISES WHICH IS OPEN MONDAY THROUGH FRIDAY 8 A.M. TO 4 P.M. IT PROVIDES A CAFETERIA, A BARBER SHOP AND A COMMISSARY WHERE PERSONAL ITEMS AND CLOTHING MAY BE PURCHASED.

Appendix B

Brief Symptom Inventory

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have. Read each one carefully, and circle the number that best describes how much discomfort that problem has caused you during the past week, including today, Please do not skip any items. If you change your mind, erase your first circle completely. Read the example below before beginning and circle the response that applies to you.

EXAMPLE: HOW MUCH WERE YOU DISTRESSED BY:

	0 NOT AT ALL	1 A LITTLE BIT	2 MODERATELY	3 QUITE A BIT	4 EXTREMELY
A. BODY ACHES . .	0	1	2	3	4

How much were you distressed by:	Not At All =0	A Little Bit =1	Moder-ately =2	Quite A Bit =3	Extreme-ly =4
1. Nervousness or Shakiness Inside	0	1	2	3	4
2. Faintness or Dizziness	0	1	2	3	4
3. The Idea That Someone Else Can Control Your Thoughts	0	1	2	3	4

		Not At All	A Little Bit	Moder-ately	Quite A Bit	Extreme-ly
4.	Feeling Others are to Blame for Your Troubles....	0	1	2	3	4
5.	Trouble Re-membering Things.......	0	1	2	3	4
6.	Feeling Easily Annoyed or Irritated....	0	1	2	3	4
7.	Pains in the Heart or Chest......	0	1	2	3	4
8.	Feeling Afraid in Open Spaces....	0	1	2	3	4
9.	Thoughts of Ending your Life.......	0	1	2	3	4
10.	Feeling That Most People Cannot Be Trusted......	0	1	2	3	4
11.	Poor Appetite.....	0	1	2	3	4
12.	Suddenly Scared for No Reason...	0	1	2	3	4
13.	Temper Outbursts That You Could Not Control..	0	1	2	3	4
14.	Feeling Lonely Even When You Are With People....	0	1	2	3	4
15.	Feeling Blocked in Getting Things Done...	0	1	2	3	4
16.	Feeling Lonely....	0	1	2	3	4

		Not At All	A Little Bit	Moder-ately	Quite A Bit	Extreme-ly
17.	Feeling Blue......	0	1	2	3	4
18.	Feeling No Interest in Things........	0	1	2	3	4
19.	Feeling Fearful...	0	1	2	3	4
20.	Your Feelings Being Easily Hurt.....	0	1	2	3	4
21.	Feeling That People Are Un-friendly or Dis-like You......	0	1	2	3	4
22.	Feeling Inferior to Others..	0	1	2	3	4
23.	Nausea or Upset Stomach...	0	1	2	3	4
24.	Feeling That You Are Watched or Talked About by Others..	0	1	2	3	4
25.	Trouble Falling Asleep...	0	1	2	3	4
26.	Having to Check and Double Check What You Do...	0	1	2	3	4
27.	Difficulty Mak-ing Decisions..	0	1	2	3	4
28.	Feeling Afraid to Travel on Buses, Subways, or Trains...	0	1	2	3	4
29.	Trouble Getting Your Breath...	0	1	2	3	4
30.	Hot or Cold Spells......	0	1	2	3	4

		Not At All	A Little Bit	Moder- ately	Quite A Bit	Extreme- ly
31.	Having to Avoid Certain Places, Things or Activities Because They Frighten You	0	1	2	3	4
32.	Your Mind Going Blank	0	1	2	3	4
33.	Numbness or Tingling in Parts of Your Body	0	1	2	3	4
34.	The Idea That You Should Be Punished For Your Sins	0	1	2	3	4
35.	Feeling Hope- less About the Future	0	1	2	3	4
36.	Trouble Concentrating	0	1	2	3	4
37.	Feeling Weak in Parts of Your Body	0	1	2	3	4
38.	Feeling Tense or Keyed Up	0	1	2	3	4
39.	Thoughts of Death or Dying	0	1	2	3	4
40.	Having Urges to Beat, Injure, or Harm Someone	0	1	2	3	4
41.	Having Urges to Break or Smash Things	0	1	2	3	4
42.	Feeling Very Self-Conscious with Others	0	1	2	3	4

		Not At All	A Little Bit	Moder-ately	Quite A Bit	Extreme-ly
43,	Feeling Un-easy in Crowds	0	1	2	3	4
44.	Never Feeling Close to Another Person	0	1	2	3	4
45.	Spells or Terror or Panic	0	1	2	3	4
46.	Getting into Frequent Quarrels	0	1	2	3	4
47.	Feeling Nervous When You Are A-lone	0	1	2	3	4
48.	Others Not Giving You Proper Credit For Your Achievements	0	1	2	3	4
49.	Feeling So Rest-less You Couldn't Sit Still	0	1	2	3	4
50.	Feelings of Worthlessness	0	1	2	3	4
51.	Feeling That People Will Take Advantage of You if You Let Them	0	1	2	3	4
52.	Feelings of Guilt	0	1	2	3	4
53.	The Idea That Something is Wrong with Your Mind	0	1	2	3	4

Appendix C

Mood Assessment Scale

1.	Are you basically satisfied with your life:	yes / no
2.	Have you dropped many of your activities and interests?	yes / no
3.	Do you feel that your life is empty?	yes / no
4.	Do you often get bored?	yes / no
5.	Are you hopeful about the future?	yes / no
6.	Are you bothered by thoughts you can't get out of your head?	yes / no
7.	Are you in good spirits most of the time?	yes / no
8.	Are you afraid that something bad is going to happen to you?	yes / no
9.	Do you feel happy most of the time?	yes / no
10.	Do you often feel helpless?	yes / no
11.	Do you often get restless and fidgety?	yes / no
12.	Do you prefer to stay at home, rather than going out and doing new things?	yes / no
13.	Do you frequently worry about the future?	yes / no
14.	Do you feel you have more problems with memory than most?	yes / no
15.	Do you think it is wonderful to be alive now?	yes / no
16.	Do you often feel downhearted and blue?	yes / no
17.	Do you feel pretty worthless the way you are now?	yes / no
18.	Do you worry a lot about the past?	yes / no
19.	Do you find life very exciting?	yes / no

20.	Is it hard for you to get started on new projects?	yes / no
21.	Do you feel full of energy?	yes / no
22.	Do you feel that your situation is hopeless?	yes / no
23.	Do you think that most people are better off than you are?	yes / no
24.	Do you frequently get upset over little things?	yes / no
25.	Do you frequently feel like crying?	yes / no
26.	Do you have trouble concentrating?	yes / no
27.	Do you enjoy getting up in the morning?	yes / no
28.	Do you prefer to avoid social gatherings?	yes / no
29.	Is it easy for you to make decisions?	yes / no
30.	Is your mind as clear as it used to be?	yes / no

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Appendix D

Morale Quality Scale

Now we would like you to complete a few questions about how things are going for you personally these days. Please read each of the following items, and put a check mark next to the one response that best indicates how you feel at the present time.

1. Do things keep getting worse as you get older:

YES_____	NO_____	DON"T KNOW_____
1	0	8

2. Do you have as much pep as you did last year?

YES_____	NO_____	DON'T KNOW_____
1	0	8

3. How much do you feel lonely?

YES_____	NO_____	DON'T KNOW_____
1	0	8

4. Do little things bother you more this year?

YES_____	NO_____	DON'T KNOW_____
1	0	8

5. Do you see enough of your friends and relatives?

YES_____	NO_____	DON'T KNOW_____
1	0	8

6. Do you feel that as you get older you are less useful?

YES_____	NO_____	DON'T KNOW_____
1	0	8

7. Do you have a lot to be sad about?

YES_____	NO_____	DON'T KNOW_____
1	0	8

8. Do you take things hard?

YES_____	NO_____	DON'T KNOW_____
1	0	8

9. Do you get upset easily?

YES_____	NO_____	DON'T KNOW_____
1	0	8

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